“The declining European defence budget and the fact that the U.S. accounts for nearly 73 percent of total NATO defence spending is unbalanced and unsustainable over time. Collectively pooling resources as part of a so-called “smart defense” strategy that calls for targeted spending on key areas of common interest is one way to deal with the consequences of a budgetary crunch.”

NATO SACEUR
• NATO Organization & Command
• Medical Support to NATO Forces
• NATO Medical Challenges
• Strategic Issues/Way Ahead
NATO Organization & Structure
What is NATO?

• Intergovernmental alliance formed in 1949 to counter threat of USSR
  • 12 original members, expanded to 28

• Key principle: collective defence
  • Article 5: an attack on one is an attack against all

• ‘A political alliance with a military capability’

• Broad security definition - NATO Strategic Concept (NSC)
  • Current 2010 NSC is only NATO’s 6th in 62 years
What does NATO do?

- Create a stable security environment
- Forge partnerships
- Lead crisis response by member states
- Combat terrorism and proliferation of weapons of mass destruction (WMD)
- Integration & standardization of military capability – but FULL C2 remains with nations
NATO’s Geographic Footprint

- **NATO member states**
- **Partnership for Peace**
- **Mediterranean Dialogue**
- **Contact countries**
Who's Who
European & NATO Cooperative Structures

ORGANISATION FOR SECURITY AND COOPERATION IN EUROPE (OSCE)

EURO-ATLANTIC PARTNERSHIP COUNCIL (EAPC) [50]

PARTNERSHIP FOR PEACE (PfP) [22]

NORTH ATLANTIC TREATY ORGANISATION (NATO) [28]

Albania  Croatia  Norway  Turkey
Canada  Iceland  United States

EUROPEAN UNION (EU) [27]

Belgium  Germany  Portugal
Bulgaria  Hungary  Romania
Czech Rep  Italy  Slovenia
Denmark  Latvia  Spain
Estonia  Lithuania  United Kingdom
Slovakia  Luxemburg  
France  Netherlands  
Greece  Poland

Armenia  Azerbaijan  Russia
Belarus  Serbia
FYROM  Switzerland
Georgia  Tajikistan
Kazakhstan  Turkmenistan
Kyrgyzstan  Ukraine
Moldova  Uzbekistan
Montenegro  Bosnia-Herzegovina
Austria  Finland  Ireland  
Malta  Sweden

Cyprus

Andorra  Holy See  Liechtenstein  Monaco  San Marino

Mediterranean Dialogue (MD) [7]

Algeria  Israel  Mauritania  Tunisia
Egypt  Jordan  Morocco

Istanbul Cooperation Initiative (ICI) [6]

Bahrain  Kuwait  Oman  Qatar
Saudi Arabia  UAE
Command of Operations

Strategic

Joint Force Command (JFC) HQ
Brunssum, NLD

ACO HQ
Mons, BEL

NATO HQ
Brussels, BEL

Operational

Joint Force Command (JFC) HQ
Naples, ITA

Joint (J) HQ
Lisbon, PRT

Tactical

CC Land
Heidelberg, DEU

CC Air
Ramstein, DEU

CC Mar
Northwood, GBR

CC Land
Madrid, ESP

CC Air
Izmir, TUR

CC Mar
Naples, ITA

NATO-UNCLASSIFIED
Medical Support to NATO Forces
Medical Support Standards

• In principle, NATO Medical Support is a national responsibility

  • *In practice it is increasingly a shared responsibility*

• Treatment outcome must equate to best medical practice

• Standards need to be acceptable to all participating nations

• Continuum of Care from injury to home base
The Medical Challenge

Joint & Combined

Expeditionary Forces
Best Medical Practice
Continuum of Care
Continuum of Care

Role 1
TCCC

Role 2 (Light Manoeuvre)
Damage Control Surgery

Role 2 (Enhanced)
Primary Surgery

Role 3
Primary and specialist surgery

Role 4 Home Base

NATO-UNCLASSIFIED
• **Enhanced first aid.** Immediate life saving measures applied by personnel trained in tactical combat casualty care. Bleeding and airway control for the most severely injured casualties to be achieved within 10 minutes of wounding.

• **Damage control resuscitation.** Measures commenced by emergency medical personnel within 1 hour of wounding.

• **Damage control surgery.** Depending on the specific and individual requirement the aim is to be able to provide damage control surgery within 1 hour, but no later than 2 hours of wounding.
Plan Review

MED Support Plan

Commander

Chief of Staff

Good work, but I think we might need just a little more detail right here.
NATO Medical Challenges
Current NATO Medical Challenges

- Theatre Reserve and High-Readiness assets difficult to fill
- MEDEVAC assets are scarce
  - Nations compensate on operations by increasing their medical ‘footprints’
- RW assets are a key-enabler to meet the 10-1-2 timelines for treatment.
- National caveats on use of their assets limit NATO’s opportunities for best collective use
NATO Medical Shortfalls

- Global under-resourcing of military medical capabilities
- Shift to civilian provision of home base health care
- Raised expectations on standards of care in field
- Nations often retain static ‘Cold War’ capabilities
- Limited medical representation in the staff of some nations
- Shortages of appropriately trained specialists in both military and civilian recruiting pools
NATO’s Strategic Concept
Lisbon Summit 2010 agreed the new NATO Strategic Concept

NATO’s roadmap for the next 10 years

Active, wider engagement

Global partners & international actors

Extending cooperative security
  - Assist partners develop capabilities
  - Gain interoperability experience

Complementary capability development for common shortfalls

http://www.nato.int/cps/en/natolive/official_texts_68580.htm
NATO’s 3 Core Tasks

• Collective Defence
• Crisis Management
• Cooperative Security

Originally planned as *Implementation Summit* for Lisbon 2010 proposals

- Background of global challenges:
  - Libya; Arab Spring; global financial position

- 4 separate Summit declarations issued:
  - Main Summit declaration
  - Transition in Afghanistan
  - Deterrence & Defence Posture
  - *Defence Capabilities: NATO Forces 2020*
NATO Forces 2020:

*Modern, tightly connected forces equipped, trained, exercised and commanded so they can operate together and with partners in any environment*

- Achieved through a new approach to multinational cooperation in NATO

- *Smart Defence* is ‘at the heart’ of it

- Connected Forces Initiative (CFI) a key element
Smart Defence
• Financial pressure
• Defence reviews
• Meeting NATO’s Essential Core Tasks:
  • Collective Defence
  • Crisis Management
  • Cooperative Security
• Trans-Atlantic relationship…
In a speech in Brussels, outgoing U.S. Defense Secretary Robert Gates said that America's military alliance with Europe faces a "dim, if not dismal" future, owing to what he characterized as the United States' disproportionate funding of NATO operations, and of allies "willing and eager for American taxpayers to assume the growing security burden left by reductions in European defense budgets."

In decrying the inability of all NATO members to contribute to operations, such as enforcing the no-fly zone over Libya, Gates said, "Frankly, many of those allies sitting on the sidelines do so not because they do not want to participate, but simply because they can't. The military capabilities simply aren't there."
I know that in an age of austerity, we cannot spend more. But neither should we spend less. So the answer is to spend better. And to get better value for money … we must seek multinational solutions. Taken together, this is what I call Smart Defence.

NATO Secretary General, Anders Fogh Rasmussen, 30 Sep 11
• Declining National fiscal support
• Resulting in individual Nation’s inability to support full spectrum of continuum of care
• Medical shortfalls persist against NATO’s Level of Ambition
• Mitigate and predict medical shortfalls thru:
  • Multinational approach to Military Healthcare
  • Modular approach to Medical Support
Smart Defence: Reason for Change

• Based on op experience, choose the standard of care NATO wants to institutionalize for the future (& resource it)

• Enable all 28 nations to make a material contribution

• Increase interoperability between the finite national medical resources available

• Improve NDPP reporting to record medical capability in greater detail assessed against a common standard
Smart Defence Initiatives

Tier 1 – Projects
• Agreed scope
• Lead nation & partners
• EU-coordinated
Total = 24

Tier 2 – Proposals
• Ambitious scope
• Interest expressed but no Lead (yet)
• EU-discussed
Total = 56

Tier 3 – Ideas
• Good ideas
• Options for the future
• Build interest
Total = 67

Project 1.15: Multinational Medical Treatment Facilities
Medical Capability Development

Multinational Healthcare Concept

Modular Approach

Policy, Doctrine, Defence Planning
Multinational Healthcare Concept

**Now NATO Policy**

Approved by NATO Military Committee:

Enclosure 1 to IMSM-0289-2012 dated 18 Jul 12
Approved by NATO Military Committee:

Enclosure 2 to IMSM-0289-2012
dated 18 Jul 12

Now NATO Policy
For **groups of nations** to be able to **pool and share** national medical capabilities and create multinational treatment facilities, either as **contingent capabilities** held at readiness or for **deployment** on operations in order to **increase the assets available** to meet NATO’s Level of Ambition and contribute to the mitigation of long-standing shortfalls in Alliance medical capability.
Project 1.15: Objective

- Create:
  - Multinational medical treatment facilities from standardized component modules
  - Standardized modular medical approach based on agreed levels of care and treatment capability
- Plug & Play: rearranged, replaced, combined and interchanged easily
- Build optimized groupings for task
  - Tailored to needs of population at risk
  - Avoid unnecessary deployment of assets
  - Minimize force protection and support burden
- Tailor level of care to the op requirement
Project 1.15: Scope

• Standardization
  • Define medical capabilities in modular terms
  • Use existing NATO standards & definitions when able

• Development
  • Commonalities in existing capabilities agreed upon
  • Individual national contributions proposed

• Pre-deployment training and evaluation
  • Develop means to combine and test national contributions as Multi-National facilities
To develop a NATO concept for modular medical capability based on standardized component modules that can be rearranged, replaced, combined or interchanged easily.

By defining and generating military medical support in terms of modular components rather than complete medical treatment facilities, utilization of existing medical assets will be improved.
Modular Approach

• **Composition:**
  - Core, Enhanced, Advanced = personnel & equipment
  - Complementary = can be personnel or equipment only, or both
  - Each module represents a functional capability
  - Complementary modules enhance a capability or create a new one
  - Lead nation ensures the modules chosen provide the level of care required

• **Standardization:**
  - Define & agree NATO standard personnel & equipment elements

• **Involve Key stakeholders**
  - NATO member/partner nations
  - National military health services
  - International organizations
  - Contracted support
  - Regional civilian resources
  - Civilian governmental and non-governmental organizations
Modular Approach

- Lead Nation role
  - C2, governance, language, clinical & laboratory standards, resupply, train TCN personnel
  - Ensures the modules chosen provide the level of care required
  - National expectations/standards of care
  - Readiness of MN force elements
  - Storage and access to modules procured by regional groupings

- Bottom Line: institutionalize basis for contingent MN medical capability
# Module Types: Primary Healthcare

## Primary Healthcare Core Modules
- Occupational Medicine (OM)
- Pre-Hospital Care & Life Support (PCLS)
- Primary MEDEVAC (PVAC)
- Primary Management (PM)

## Primary Healthcare Complementary Modules
- Nursing
- Dental
- Laboratory
- Tropical Medicine
- CBRN
## Module Types: Surgery

### Surgery Core Modules
- Surgical Care (SC)
- Resuscitation (RE)
- Pre-Hospital Care & Life Support (PCLS)
- Primary MEDEVAC (PVAC)
- Primary Management (PM)

### Surgery Enhanced Modules
- Damage Control Surgery (DCS)
- Radiography (RAD)
- Laboratory (LAB)
- Ward (WD)
- Supply (SUP)
### Module Types: Specialist Care

#### Specialist Care

<table>
<thead>
<tr>
<th>Enhanced Modules</th>
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<tbody>
<tr>
<td>• Sterilization (S)</td>
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<tr>
<td>• Mental Health (MH)</td>
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<tr>
<td>• General Ward (GW)</td>
</tr>
<tr>
<td>• Enhanced Imaging (EI)</td>
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<tr>
<td>• Patient Transfer (PT)</td>
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</tbody>
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<tr>
<th>Advanced Modules</th>
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<tbody>
<tr>
<td>• Neurosurgery (NS)</td>
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<tr>
<td>• Ophthalmic Surgery (OS)</td>
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<tr>
<td>• Head &amp; Neck Surgery (HNS)</td>
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<td>• Plastic Surgery (PS)</td>
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<tr>
<td>• Advanced Supply (ASUP)</td>
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</tbody>
</table>
Contracted Operational Medical Support: Enhances or compliments military capability

Private Sector Capability

Outputs

- Collaboration with potential private partners
- NATO concept for Contracted Operational Medical Support
- Develop a NATO contractual framework & requirements matrix
Questions?
BACKUP SLIDES
Generating Levels of Care

• Level of Care ‘A’:
Location W = PCLS + PM + PVAC + OM + D

• Level of Care ‘B’:
Location X = PCLS + RE + DCS + PM
Location Y = PCLS + RE + SC + PM + CBRN

• Level of Care ‘C’:
Location Z = PCLS + RE + EI + SC + HNS
PM + OM + MH + D + PT
EMEDS Modular Build-Up and Full Operational Capability Timelines

<table>
<thead>
<tr>
<th>Capability</th>
<th>24 hrs</th>
<th>48 hrs</th>
<th>72 hrs</th>
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<tbody>
<tr>
<td>EMEDS Basic</td>
<td></td>
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<td>EMEDS+25 (25 beds)</td>
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<td></td>
<td>(4 holding beds)</td>
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<td>Medical Command</td>
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<td>Health Services Admin</td>
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<td>Medical Logistics</td>
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<td>Field Surgery</td>
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<tr>
<td>Dental</td>
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<tr>
<td>Preventive Medicine (public health, BEE, IDMT)</td>
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<tr>
<td>Primary Care or Flight Medicine</td>
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<tr>
<td>Critical Care</td>
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<td>Pharmacy</td>
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<td>Radiology</td>
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<tr>
<td>PAM Augmentation*</td>
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<td>Specialty Care Augmentation*</td>
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<td>IHS*</td>
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<tr>
<td>Complex Med/Surg Services</td>
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<tr>
<td>Enhanced Critical Care</td>
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<tr>
<td>Enhanced Medical Logistics</td>
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<tr>
<td>Laboratory</td>
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<tr>
<td>PAM Augmentation</td>
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<tr>
<td>6 Additional Beds</td>
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<tr>
<td>All EMEDS Basic Capability</td>
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<tr>
<td>All EMEDS+10 Capability</td>
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<tr>
<td>Enhanced Dietary Services</td>
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<tr>
<td>Expanded Medical Logistics</td>
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<tr>
<td>Expanded Ancillary Services</td>
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<tr>
<td>Expanded Med/Surg Services</td>
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<tr>
<td>Dental Augmentation</td>
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<tr>
<td>Surgical Augmentation</td>
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<tr>
<td>15 Additional Beds</td>
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<td>All EMEDS Basic Capability</td>
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<td>All EMEDS Basic Capability</td>
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BEE: Bioenvironmental Engineer; PAM: Preventive Aerospace Medicine; IDMT: independent duty med tech;